DOCUMENT RESUME

ED 150 505 CG 012 172

AUTHOR Chopra, Khem S.; And Others
TITLE The Efficacy of Constructive Coercion in an Alcoholic Rehabilitation Programme.
PUB DATE Jul 77
NOTE 18p.; Paper presented at the meeting of the Canadian Addiction Foundation (Winnipeg, Manitoba, July, 1977)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS *Alcoholism; *Drinking; *Employer Employee Relationship; *Intervention; Program Descriptions; *Rehabilitation Programs; Socially Deviant Behavior; Social Problems; Work Environment
IDENTIFIERS *Constructive Coercion

ABSTRACT

Two groups of employed men in an alcoholic rehabilitation program, one referred through an organized policy of constructive coercion and the other composed of volunteers, were compared to test the efficacy of constructive coercion in the rehabilitation process. It was found the patients referred by constructive coercion were younger, had fewer psychosocial problems, had a higher percentage abstinent, and had higher rates of compliance with follow-up. It was concluded that a policy of constructive coercion does allow earlier identification of workers with alcohol problems and does improve the chances for a positive treatment outcome. (Author)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED150505

The Efficacy of Constructive Coercion In an Alcoholic Rehabilitation Programme*

By

Khem S. Chopra M.S.W. M.B.A.
Chedoke Hospitals

and

Donald A. Preston M.A.

Lowell W. Gerson Ph.D.

Department of Clinical Epidemiology and Biostatistics

Faculty of Health Sciences

McMaster Medical Centre

Hamilton, Ontario

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Khem Chopra

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

* Revised version of a paper presented at Canadian Addiction Foundation, Winnipeg, Manitoba, July, 1977

CG012172

Acknowledgements

Supported by:

Research grant 1212-5-219
Non-Medical Use of Drugs Directorate, Ottawa

and by

Research Grant from Hamilton Psychiatric Hospital, Hamilton

The Efficacy of Constructive Coercion In an Alcoholic Rehabilitation Programme

Alcohol related problems appear in many locations, one receiving increasing attention is the workplace. The past thirty years have seen major changes in our philosophy toward and in our identification and treatment of workers with alcohol problems (1, 2, 3, 4, 5). Modern industrial alcoholism rehabilitation programs originated in the 1940's when a few companies allowed Alcoholics Anonymous (A.A.) access to the work site. Over the years these informal arrangements became formal, professionalized, and frequently part of collective bargaining agreements. Today, alcoholic rehabilitation programs provide in-patient services to employees referred for treatment under a policy called "constructive coercion" or "constructive confrontation". This policy directs a supervisor to confront a worker with his record of substandard performance and, if the cause of the inadequate performance is alcohol-related, forces him to seek treatment.

The assumption which underlies constructive coercion is similar to that part of the A.A. philosophy which holds that a problem drinker will only become motivated to seek treatment when a crisis occurs, when he hits bottom. In constructive coercion the employer, by the confrontation, precipitates the crisis; in A.A. jargon this is known as "raising the bottom". When the threat of termination is genuine, programme advocates insist, most workers choose treatment. This leverage makes it possible to interrupt a drinking career and intervene before problems become unmanageable. Early intervention can lead to improved rates of recovery (6).

To achieve these dual ends of early detection and better rehabilitation (primarily abstinence) most occupational programmes include the following steps:

1. Identification of a work problem
2. Diagnosis of the problem as alcohol-related
3. Treatment of the alcohol problem
4. Follow-up

Alcoholic rehabilitation programs are widespread in government, private industry and service organizations, yet few investigations have examined the efficacy of a policy of constructive coercion. Two recent studies reach different conclusions with regard to its value. Himes and Smart (7) compared the self-reported drinking behaviours and supervisor ratings (including absenteeism and lateness) of two groups of workers entering treatment and conclude coerced patients showed no greater improvement than did volunteers. Heyman (8) compared groups of strongly and minimally coerced workers on self-assessment of job performance after discharge from treatment. She found that more of the strongly coerced patients reported work improvement. The efficacy of constructive coercion as part of a treatment package is still uncertain; two questions must be answered:

1. Does a policy of constructive coercion allow earlier identification and treatment of workers with problem drinking?
2. Do workers referred to treatment under a policy of constructive coercion have better outcomes than those who are self referred?

Our local situation, with one alcoholic rehabilitation program treating workers, either referred through an industrial alcohol program (constructive coercion) or self referred, gave us the unique opportunity to test these two questions. Before describing the design of these tests, we will briefly discuss the salient features of the industrial alcoholic and treatment programs.

The Industrial Alcoholism Program

The largest employers in the region have organized a co-ordinated effort, called the Employee Assistance Programme, to provide treatment for workers with alcohol problems. The objectives of this program are:

1. To promote the adoption of supervisory training in detection of alcohol related work problems.
2. To develop methods for monitoring work performance.
3. To arrange for assessment and diagnosis for workers with possible alcohol problems.
4. To encourage active in-patient treatment in an alcoholic rehabilitation programme.
5. To provide follow-up and support for workers completing the in-patient programme.

Workers identified through this programme are referred for treatment to the Alcoholic Rehabilitation Programme (ARP).

The Alcoholic Rehabilitation Programme

The administrative aegis of the Alcoholic Rehabilitation Programme has recently been transferred from a psychiatric to a general hospital. At the time of the study it was a 22 bed residential treatment programme for male and female alcoholics living in the catchment area of the psychiatric hospital. Patients normally experienced a three week hospital stay and a tailored follow-up.

Treatment was based on a multi-dimensional theory of alcoholism. Services included a combination of individual and group counselling, psychotherapy, recreation therapy and relaxation therapy. Drugs were administered if necessary and all patients had to agree to protective medication, Temposil® or Antabuse®. Total abstinence was the main criterion of improvement. To be eligible for the program patients must be:

1) detoxified;

2) free of any serious physical illness;

3) free of any serious psychiatric illness;

4) free of pending legal charges.

After active treatment, in the first month of follow-up staff maintained weekly contact with each patient. Monthly contact was continued for a maximum of 14 months.

METHODS

To answer the two questions previously stated we will compare the records of two groups of employed men who were treated for alcohol problems by the ARP. One group, our target, was referred through an industrial alcohol programme; the others came to treatment through a variety of referral sources. We will call the target group *coerced* and the second group *volunteers*. This second name is not, in the strictest sense accurate, for while many are volunteers others may have been coerced by other sources, spouses, the courts, etc. However, the significant issue is that they were not referred through the organized industrial policy of constructive coercion. We developed *a priori* criteria which we would accept as evidence in answering each of the two questions under consideration.

To determine if a policy of constructive coercion allows earlier

identification and treatment of alcohol problems requires that we know when the problem began. The lag between the time of problem onset and recognition of the problem for the target group and the controls could be compared; if constructive coercion has any advantage it would show in this difference. However, it is impossible to tell when the alcohol problem actually started; the only point about which there is certainty is when it was identified. While we cannot pinpoint when alcohol-related problems began for any individual, it seems reasonable to assume that the mean age of onset for drinking problems was the same for each group. If so, proof that constructive coercion leads to early identification is that the coerced group would be younger than the volunteers. Furthermore, a group identified earlier should have fewer problems associated with alcohol; they would have fewer years at risk. In this study, as no patients with severe psychiatric or physical problems were allowed into the program we focused solely on social problems. Consistent with younger age, fewer social problems in the coerced group serves as evidence of earlier identification.

Evidence of a better treatment outcome for the industrially referred group is that fewer coerced workers lost to follow-up and a higher proportion of coerced workers would be abstinent. All coerced patients are prescribed a fourteen month follow-up, while voluntary patients, over whom the treatment workers have no control, typically receive less. This provides a conservative test, for the target group, in order to be successful, must remain in follow-up and be abstinent for longer periods.

Information necessary for these comparisons was abstracted from the ARP treatment records. The form used was developed to code most significant features of the charts. From the outset we were interested in the issue of industrial referrals and included a question regarding source of referral; also recorded were:

1. Standard demographic data
2. Physical findings
3. Psychosocial problems
4. Laboratory findings
5. Therapists assessment at discharge and during follow-up

The actual abstracting was performed by coders who were unaware of our interest in industrial referrals.

RESULTS

The results presented are based on records of all 207 men admitted to the ARP in 1974 or 1975 and who were employed at the time of admission. Eighty-six were referred through the Employee Assistance Plan, 121 employed men came from other referral sources.

(TABLE 1 ABOUT HERE)

Employment status is one major predictor of success for alcohol treatment (9); the other is marital status (10). As well those included in this study are employed it was important to consider whether the groups differed in this other dimension. Table 1 shows they are remarkably similar (even though they differ from the marital patterns in the rest of Hamilton - in our group fewer are married).

(TABLE 2 ABOUT HERE)

Table 2 presents information relevant to the first question; we show there are significant differences in the age distribution between the two groups. The coerced group tends to be younger; one-fourth are under 30 years while less than 10% of the volunteers are in this age category. One-third of the volunteers are in the decade 31 - 40. Above 40 the age distribution between groups appears quite similar.

(TABLE 3 ABOUT HERE)

Table 3 shows the younger coerced group demonstrates less pathological behaviour; however, in most cases the rates are not very high. It should be noted that auto accidents and suicide attempts do not fit the pattern. Suicide and attempted suicide is a phenomenon of the young and the very old. Thus in both our groups patients have either survived the age at which suicide attempts are most common or have not reached the age at which they are likely to try again. In short both groups had equal and complete exposure at the younger years when suicide is likely. For the other pathologies, the groups have not outgrown the age of increased risk. That the proportion of attempted suicides was equal in each group was somewhat gratifying as it was expected and does instill some confidence in the data. Even with the anomaly of auto accidents the weight of the evidence clearly supports the contention of occupational programmes; they do appear, at least for these two groups, to identify problem drinkers at a younger age. The natural consequence of younger age at identification is fewer problems associated with drinking.

The final event of the active treatment phase is a prognosis formed by the therapist with the most knowledge of the case. At discharge, therapists

predicted 50% of each group would have a good outcome (abstinence) by the time of the first follow-up evaluation.

(TABLE 4 ABOUT HERE)

The first follow-up evaluation occurs when patients return one week after discharge. Over three-quarters of the coerced group, but only one-half of the volunteers reported continuing abstinence at this point (Table 4). It is important to note the high rate of non-compliance among volunteers; almost one patient in five did not appear for the assessment.

(TABLE 5 ABOUT HERE)

Table 5 shows that nearly half the coerced group were abstinent and only 9% were lost to follow-up at the end of 14 months. Only one-third of the volunteer group was successful and 18%, or twice the rate of the coerced, were lost to follow-up. While it is possible that these men were lost to follow-up because they were completely cured, it seems unlikely that this was the case. Even if it was, compliance with follow-up is still an important outcome and the coerced group was clearly more compliant.

DISCUSSION

The evidence presented certainly supports the concepts underlying Employee Assistance Programmes. We found:

1. Patients referred under the policy of constructive coercion enter treatment at younger ages.

2. These patients have experienced fewer problems associated with alcohol;
3. they report a higher percentage abstinent during follow-up; and
4. compliance with follow-up is increased.

The two questions raised regarding the efficacy of EAP's and constructive coercion are answered yes; EAP's do allow earlier identification and they do improve the chances for a positive outcome.

What happens in follow-up and how accurate are self reports, are concerns we have with our study, and also with the work of others. Charlebois (11) showed for a group supposedly successful in treatment, absenteeism and on the job accidents declined but accidents away from work actually increased. If alcohol were involved in this non-workplace behaviour, we may well have reason to doubt the truthfulness of self-reports regarding abstinence. We don't know if alcohol was involved. Studies must be designed which permit careful follow-up of all patients.

At the end of treatment half of each group was expected to do well; half of the coerced group did, (although not necessarily the same half as were expected). Steady surveillance on the job may be a more powerful force in recovery than the entire chain of initial detection, assessment, referral and treatment. If so, findings such as those reported by Edwards (12) where identification and scrutiny alone achieve outcomes equal to elaborate rehabilitation programs are given increased value. It may be surveillance is the most cost-effective method for diminishing the impact of alcohol problems in the workplace. The large and expanding efforts in occupational alcoholism programming (13, 14) compel us to carefully evaluate the premises upon which treatment is built.

References

1. Stevenson, R. W., "Absenteeism in An Industrial Plant Due to Alcoholism". Quarterly J. of Studies on Alcohol, Vol. 2, 1942.

2. Archibald, H. O., "How Many Alcoholics in Your Firm?" Financial Post, Toronto, June 19, 1954.

3. Trice, H. M., "Work Accidents and the Problem Drinker: A Case Study," Industrial Review, Vol. 3 (2) 1957.

4. Trice, H. M., Alcoholism in America, McGraw-Hill Book Company, New York, 1966.

5. Pell, S. and D'Alonzo, C.A., "Sickness Absenteeism of Alcoholics," Journal of Occupational Health, Vol. 12 (6) 1970.

6. Hawker, A., "The Importance of Early Recognition and Treatment for the Alcoholic Employee," The Journal of Alcoholism, Vol. 8 (2) Summer, 1973, pp. 68-69.

7. Himes, Mavis and Smart, Reginald G., "A Follow-Up Study of Employed Alcoholics Treated Voluntarily and Under Constructive Coercion", unpublished substudy no. 509, Project no. 141, 1972, Addiction Research Foundation, Toronto, Ontario.

8. Heyman, Margaret M., "Referral to Alcoholism Programmes in Industry: Coercion, Confrontation and Choice," Journal of Studies on Alcohol, Vol. 37 (7) July, 1976, pp. 900-907.

9. Gerard, D. and Saenger, G., Outpatient Treatment of Alcoholism, Brookside Monograph, No. 4, 1966, University of Toronto Press.

10. Myerson, D. J. and Mayer, J., "Origin, Treatment and Destiny of Skid-Row Alcoholic Men," New England Journal of Medicine, 1966, Vol. 275, pp. 419-425.

11. Charlebois, Elizabeth-Jean, "Evaluation of an Industrial Alcoholic Rehabilitation Program," M.Sc. Thesis, Department of Epidemiology and Biostatistics, McMaster University, 1976.

12. Edwards, G., Orford, J., Egert, S., et al., "Alcoholism: A Controlled Trial of 'Treatment' and 'Advice'," Journal of Studies on Alcohol, Vol. 38, No. 5, 1977, pp. 1004-1031.

13. Murry, R. M., "Alcoholism and Employment," Journal of Alcoholism, Vol. 10 (1) 1975.

14. Williams, R. L. and Moffat, G. H. eds., Occupational Alcoholism Programme, Charles C. Thomson Company, Springfield, Illinois, 1975.

TABLE 1

MARITAL STATUS OF EMPLOYED MALES

Marital Status	Coerced		Volunteers	
	N	%	N	%
Single	8	9.3	14	11.6
Married and CLU	54	62.8	73	60.3
Separated	17	19.8	25	20.7
Divorced	6	7.0	8	6.6
Widowed	1	1.2	1	.8
Total	86	(100.1)	121	(100)

$X^2 = .38$, 4 df NS

TABLE 2

AGE DISTRIBUTION OF EMPLOYED MALES

	Coerced		Volunteers	
Age	N	%	N	%
≤ 30	21	24	10	8.2
31-40	18	20.9	39	32.2
41-50	31	36.0	48	39.7
≥ 51	16	18.6	24	19.9
Total	86	(99.9)	121	(100)

$X^2 = 11.30$, 3 df sig $p < .01$

TABLE 3

PROPORTION OF EMPLOYED MALES WHO HAVE EVER EXPERIENCED A SELECTED PSYCHOSOCIAL PROBLEM

Problem	Per Cent Ever Had	
	Coerced	Volunteers
Arrest for Non Violent Crime	3.5	14.0
Arrest for Violent Crime	4.7	8.3
Accident at Work	2.3	6.8
Auto Accident	18.6	9.2
Impaired Driving Charge	10.5	18.2
Suicide Attempt	5.8	5.0

TABLE 4

THERAPIST'S ASSESSMENT ONE WEEK AFTER DISCHARGE

	Assessment			
	Coerced		Volunteers	
Condition	N	%	N	%
Favorable Outcome				
Abstinent	67	77.9	62	51.2
Unfavorable Outcomes				
Unchanged Drinking	3	3.5	0	--
Uncertain	8	9.3	38	31.4
Unknown	8	9.3	21	17.4
Total	86	(100)	121	(100)

X^2 15.22, 2 df sig p < .001

TABLE 5

THERAPIST'S ASSESSMENT AT END OF FOLLOW-UP

	Assessment			
	Coerced		Volunteers	
Condition	N	%	N	%
Favorable Outcome				
Improved	41	47.7	41	33.9
Unfavorable Outcomes				
Unchanged	4	4.7	0	--
Deteriorated	13	15.1	4	3.3
Uncertain	20	23.3	54	44.6
Unknown	8	9.3	22	18.2
Total	86	(100.1)	121	(100)

$X^2 = 4.00$ 2 df sig $p < .05$